	Question	Answer
A. Reporting Questions		
1	**What are the primary payor categories?**	Definitions relating to primary payor categories for reporting of Exhibits 32, 33, 34 and 46 may be found within the ICR instructions. Further clarification on specific primary payors as it relates to Exhibit 46 HFAL reductions are provided below: **Insured** means at least one provided service is covered by at least one of the patient's third-party payors. It is not necessary to collect from the third-party. HFAL reductions for these accounts are reported in the primary payor's charity line. (For 2021 ICR, Essential Plans are included as insured.) **Uninsured** means the hospital expects a patient with NO third-party coverage for ANY service provided in the account to pay at least a portion of the charges. This includes patients electing to self-pay instead of billing third parties. **Free, Charity** is for patients for whom application of the hospital financial aid policy (HFAL) results in reduction (write-off) of charges to zero. They should initially be recorded at the same value as other patients. (This determination should occur approximately when service begins, but often the determination happens during or after service—such as after receiving a charity care application.) Charity care determination or documented presumptive eligibility per HFAL Policy.
2	**Why have self-insured questions been added to Exhibit 1?**	The "Self-insured" primary payor category describes healthcare plans for which the plan owners, usually employers, have financial risk for high-cost patients versus pay per-member amounts. Self-insured plans normally are administered by a third-party administrator (TPA). TPAs often also provide other indemnity products with similar insurance cards. Most self-insured plans use reinsurance to manage high-cost risk. Self-insured plans may be in place for the hospital and for community employers. One resource to test the plan status is the Health Care Reform Act (HCRA) Elector List where the current type of coverage and dates are listed. Since some hospitals report services to their employees as self-insured, regardless of being indemnity products, the new Exhibit 1 questions clarify some information for Edits 43218 to 43226 which identify Exhibits 3 and 32 agreement regarding Courtesy primary payor reporting.
3	**Are hospitals required to report utilization and revenue for the new "Essential Plan 200-250" payer category for the 2024 ICR?**	Encounters covered by third-party payors under Essential Plan 200-250 should be reported within the new primary payor's lines in Exhibits 32, 33, 34 and 46. Since changes to hospitals' systems may not have been in place at 4/1/2024 (when Essential Plan 200-250 began), separate reporting will be optional for ICR reporting years 2024 and 2025 and mandatory for ICR Report Year 2026.
4	**What primary payors should FIDA and FIDA-IDD dual-eligible encounters be assigned to?**	Due to the change in the Medicaid DSH Cap calculation in the CMS Third Party Payor Final Rule, FIDA and FIDA-IDD dual-eligible encounters are to be assigned to the Medicare HMO primary payor in ICRs submitted for Report Year 2022 and later.
5	**What primary payors should Medicaid Pending, Medicaid Applied For or similar encounters be assigned to?**	Due to the change in the Medicaid DSH Cap calculation in the CMS Third Party Payor Final Rule, if an encounter has no item covered by another third-party payor and the patient has applied for but not yet been approved for Medicaid coverage for any part of the encounter, then it is to be reported within the Uninsured/Self-Pay primary payor. If Medicaid coverage is received, then see the next Question.
6	**In what circumstances, such as later coverage determination, may a change in the primary payor be appropriate?**	The Primary Payor is expected to be set at the encounter start; however, there are circumstances where the hospital may, but is not required to, update this because the apparent payor was changed. For example, this includes: when a payor reports retroactive coverage; when the hospital judges that an encounter THAT IS NOT COVERED BY A THIRD-PARTY PAYOR is fully charity care; or when the wrong payor was identified. Primary payor changes are not to occur as the account cascades from a valid primary payor to secondary payors, including self-responsible.
7	**What is the definition of expense related to an interest rate swap?**	As with any hedge, interest rate swap contracts vary. Financial institutions incur costs in making and providing these swaps, therefore, hospitals encounter initiation and ongoing maintenance fees and costs for the hedge (swap). These costs may include interest at the fixed-rate that is in excess of the floating (variable) rate, especially early in the arrangement while the variable rate is temporarily frozen or has not risen much. When a financial arrangement includes an interest rate swap, the hospital is expected to identify the costs of the swap and report them properly in any Federal healthcare program cost report. In addition to excluding stated fees and costs and additional interest expense when the fixed-rate exceeds the variable rate, this may require the hospital to adjust reported costs with the implicit value of the swap arrangement, if not explicitly stated in the contract. Hospitals' methods for recording transactions also vary, therefore there is not a single approach to how and where within the financial reporting system they are reported. The Department suggests that the controller or CFO can provide insight into the local method(s) applied and underlying contracts.

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8	**For Exhibit 30, Line 60, Dual-eligible, what meant by "A payor on the account"--are these Medicaid paids or Eligible for payment?**	Hospitals should identify encounters with Medicaid coverage in addition to other coverage in a manner consistent with their Medicaid DSH reporting. Under the CMS change for 2021 Medicaid DSH, pending- or applied-for-Medicaid payors do not satisfy the Medicaid coverage part of dual-eligible.
9	**What approval is needed to change the ICR Schedule 1B basis from visits to charges?**	If a provider has utilized visits as a transfer basis statistic in the prior year, they may change to charges in the current year with no prior approval. Once an ICR has been submitted with charges used as the basis to determine transfer costs, the provider will no longer be permitted to change back to visits. The change is elected within the service area on Exhibit 31A.
10	**If the 2021 Software indicates that, for a service area (Emergency, CPEP Emergency Service, CPEP Observation Beds or Clinic), "Charges" was the prior-year allocation basis, what options are available?**	ICR Schedules 1B compute the amount of routine and capital costs transferred to and from four outpatient service areas. The three historical service areas (Emergency, CPEP Emergency Service and Clinic) computed in ICR Schedules 1B are based on either the Exhibit 31A visits or Exhibit 46 charges reported in the ICR. During 2020, CPEP Observation Beds transitioned to an outpatient service only (Exhibit 33 reporting) and an ICR Schedule 1B was established for which all hospitals' bases are charges. If the previous year basis was charges, then for that service area in the 2020 and later ICR: Exhibit 31A will not be available and ICR Schedule 1B will only present transfers based on charges.
11	**What is expected reporting of CPEP Observation services?**	When a patient's status is CPEP Observation, report the Number of CPEP Observation Days in Exhibit 33 00160/814 - 00160/833. These days are paid at an inpatient rate regardless of subsequent admission. For Psychiatric admissions, NYS billing rules instruct hospitals to make the date of admission the earlier of when ordered to CPEP Observation or inpatient status. For those admitted to inpatient status, these days from Exhibit 33 00160/814 - 00160/833 are excluded from Exhibit 33 00240/814 - 00240/833. **DO NOT REPORT THE SAME CPEP Observation DAY IN EXHIBIT 32 AND IN EXHIBIT 33 Class Code 00160.** CPEP Observation routine charges are to be reported on the Exhibit 46 Line (001-015) for the area where the patient began the encounter under the Charge Code column (service area) under which the discharge was billed.
12	**Where should Hospice days reported on S-3 part I line 24.10 or another Hospice line be reported as it relates to Exhibit 32? Are Hospice Days considered ALC?**	No, Hospice days are not considered ALC. Hospice is a program that provides care to terminally ill individuals that focuses on easing symptoms rather than treating disease. The hospice benefit is not an Inpatient hospital service unless the patient is admitted as a hospital (not Hospice) inpatient. Therefore, Exhibit 32 should not include days paid for "General Inpatient Care" and "Inpatient Respite Care" for Hospice services. NYCRR Title 10, Section 86 -1.15 (h) defines Alternate Level of Care services as "those services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available." Third-party payers often term these “custodial care” services.
13	**Are we to carve the amounts on Exhibit 46 lines 382, 386, 383 and 391 out of the allowances where they would normally be reported under primary insurance?**	Because of the Report Year 2019 change in reporting HFAL reductions, an example using Third-Party is as follows: • If application of the HFAL results in write-off of ALL charges for an account with NO services covered by ANY third-party payor, report full charges under Primary Payor Free (Charity, Hill-Burton) on Line 313 and Line 391. (Line 355, Allowances for the Free Primary Payor, would rarely be used, but, if used, the Line 355 amount would not also be reported in Line 391.) • For an account with NO services covered by ANY third-party payor where some payment is expected from/for the patient, report full charges under Primary Payor Uninsured/Self-Pay on Line 311 and HFAL write-off on Line 391. • For accounts with at least one service covered by a third-party payor, report full charges under the applicable primary payor category and HFAL write-offs on Line 382, 383 or 386. Use the primary payor's category and do not split among lines.
14	**How are charges written-off (reduced) because of the hospital Financial Aid Law (HFAL) Policy to be reported in Exhibit 46?**	If the charity care determination and HFAL Policy apply to other or future encounters of the patient/guarantor, then determine the primary payor in absence of the HFAL determination and maintain its alignment throughout ICR reporting. When the primary payor would have been Uninsured/Self-pay and ALL encounter charges are written off, then report as Free (Charity, Hill-Burton) primary payor.
15	**Are we to report lines 382, 383, 386 and 391 based on accrual or actual write-offs?**	The Department expects the accounting basis of amounts reported on lines 382, 383, 386 and 391 to be consistent with that for the remainder of Exhibit 46.

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16	**What changes are required for drugs paid outside the rate code?**	At this time, for ratio-of-cost-to-charges (RCC) development, ICR Instructions require adjustment as paid outside the rate only of the amounts of all patients' outpatient chemotherapy drug costs in Exhibit 11 and charges in Exhibit 51 (Please refer to ICR instructions). Should the initial cost for Exhibit 11 be entered into a cost center other than Cost Center 123, the hospital should make adjustments or reclassifications to align the cost center of the automatic adjustment with underlying costs and charges.
17	**What professional services may be reported within the Exhibit 50 HFAL costs (charges) and payments?**	Professional services that are or may be discretely billed are to be excluded from Exhibit 50 costs/charges and payments. If the hospital billed a global charge and it could have billed the professional and technical components separately, then the charges (costs) and payments for the professional component are to be excluded from Exhibit 50. (Services paid under the FQHC and RHC fee schedules are generally exceptions because the professional component cannot be separately billed for providers that receive the full FQHC/PPS rate.)
18	**Are hospitals required to complete the new demographic table that was added to Exhibit 50 the 2024 ICR?**	Yes, those reporting changes related to demographics were based on new legislation effective in October 2024. Reporting demographic information on encounters prior to then is not required. All hospitals will need to complete the updated questions and the Zip Code Table covering their entire reporting period in Exhibit 50. For hospitals where the ICR Report year end is 9/30/2024 or earlier, ther are no required encounters on which to report demographic information in the 2024 ICR. For the remaining hospitals, the 2024 ICR will include a partial year of demographic data. If there questions or concerns on Exhibit 50 reporting requirements, reach out to HFAL@health.ny.gov .
19	**Since Rural Health Clinics (RHCs) are paid under the all inclusive rate and professional cost is left in allowable expenses, do professional charges need to be backed out on Exhibit 51?**	If the provider has elected to be reimbursed the NYS Medicaid FQHC/PPS rate for their RHC(s) (reported on CMS line 88 and subscripts thereof) and the provider has included the professional charges on Exhibit 46, then no adjustment is required on Exhibit 51.
20	**Do school of nursing non-comparable costs include other allied health education programs? For example, school of radiology or pharmacy residency program.**	No, although Medicare reporting for Nursing Programs (Schools of Nursing) and allied health education programs are similar, NY State only computes non-comparable amounts for Schools of Nursing.
21	**When will the 2024 RHCF-2/4 report be due?**	Any questions regarding reporting or submission of the RHCF cost reports should be directed to the Bureau of Nursing Home and Long-Term Care Rate Setting at rhcf-hcs@health.ny.gov.
22	**What should be done when the ICR software identifies a non-fatal edit?**	Non-fatal errors (4xxxx) and Informatory messages (5xxxx) point out unusual conditions or amounts in the ICR. If any inputs that caused the edit are incorrect, please correct the inputs, save and run the Calculate function. This may clear the edit. If an edit is to remain, the Edit Report explanation is to provide insight about why the unusual situation need not be changed.
23	**How should the Health Care and Mental Hygiene Worker Bonus Program (HWB) be reported?**	The amounts received by **ALL** Hospitals for the HWB Program are to be reported at Exhibit 27, Lines 212-214. (This might require an Exhibit 28, Reconciliation to the Audited Financial Statements entry.) Because these are not allowable amounts for rate-setting, make Exhibit 12 Reclassifications to Cost Center 003 from the cost centers where recorded when paying the HWB to employees. Then make one or two Exhibit 14 All-payor Adjustments to Cost Center 003 to remove this cost, depending on how cost was recorded. **If the hospital included HWB payments in the balance sheet, ensure there are no amounts in the Exhibit 11 trial balance, after adjustments.**
24	**For ICR Exhibits 32, 33 and 34 reporting, does the Uncompensated Care Collection (UCC) amount include the uninsured HCRA surcharge?**	Based on the latest Department guidance, provided for the 2019 Medicaid DSH Audit, that "Per the Preamble to the 2008 DSH Final Rule regarding provider health care taxes, the Department of Health (DOH)'s position for the Medicaid DSH Audits has historically been that payment amounts cannot be offset by the amount of the HCRA surcharge. Therefore, hospitals should not reduce their payments amounts by the HCRA surcharge.", the reported UCC should include the HCRA surcharge.
B. Software Questions		
25	**What is the username and password to download the ICR Software?**	The 2024 ICR Software is available to download from the Health Financial Systems (HFS) website. The link is available within the Hospital ICR application of the Health Commerce System (HCS) secure website.

	Question	Answer
26	**We have already started entering 2024 data. Will we have any problems saving our work once the updated software is installed?**	There should not be any problems with saving work once the 2024 HFS software updates have been applied using its Report Wizard. Please note that where the ICR Instructions, entry or Exhibit definitions have been modified, the hospital should verify that previously entered amounts are still accurate and properly reflect the revised ICR.
27	**What ICR software should be used?**	All ICR submissions must use the HFS MCRIF32 Software.
C. Audit Fee Questions		
28	**What are the fees associated with submitting an ICR?**	The ICR audit fees are based on Exhibit 11, column 3, line 960 **total expenses** at Class code 00042, line 960 of the previous year's report. The audit fee levels are posted on the DOH website at: http://www.health.ny.gov/facilities/hospital/audit_fee/index.htm For cost report audits for years 2024 and prior, the audit fee payments have been based on the above costs at the following fee amounts: <$50 million = $ 5,000 $50 - $100 million = $ 7,500 $100 - $300 million = $10,000 $300 - $700 million = $15,000 $700 - $1 billion = $20,000 $1 - $1.5 billion = $30,000 >$1.5 billion = $40,000
D. ICR Audit Questions		
29	**Is the Hospital Financial Assistance Law (HFAL) questionnaire used solely to determine compliance? Are hospitals field audited on HFAL compliance?**	All hospitals' questionnaire responses are used to determine HFAL compliance and are used during the ICR desk audit process. Hospitals selected for ICR field audits have additional procedures performed to complete the HFAL compliance determination.
30	**If a hospital is not found to be in substantial compliance with the HFAL, how long does it have to correct the issue?**	As with any ICR Audit finding, for an HFAL non-compliance finding, the hospital is to provide a corrective action plan (CAP) with a "completed-by" date for the Final Audit Dashboard. The Department has the final determination in whether this CAP results in compliance and its timing is appropriate.
E. General Questions		
31	**How is the information in cost reports used by the Department?**	The data in the report is used by the Department for data analysis, rate development, the Upper Payment Limit calculation, Disproportionate Share calculation and development of fund distributions. Certain data elements in the ICR are also used by other Agencies.
32	**Will the DOH accept an electronic CEO signature page at some point like the Medicare Report does?**	There are internal discussions on the possibility of moving to an electronic certification. However, at this time, we will continue to collect signed CFO certifications in PDF format.
33	**Who should I contact with ICR related questions? Other contacts?**	**ICR questions can be answered using the following emails:** General ICR Questions**:** Hospital.ICR@health.ny.gov Audited Financial Statements must be emailed in pdf format to: AFS@health.ny.gov HFAL Exhibit 50 reporting requirements: HFAL@health.ny.gov KPMG ICR Audit Contact: us-albadvnysdhicr@kpmg.com **Other resources include:** Hospital Inpatient or Outpatient Article 28 rates: HospFFSUnit@health.ny.gov Hospital Outpatient Services for Article 32 (OASAS), Article 31 (OMH) & Article 16 (OPWDD) providers or rates: https://www.health.ny.gov/health_care/medicaid/rates/contacts/ Medicaid Managed Care Premiums and Rates: bmcr@health.ny.gov Residential Health Care Cost Reports: rhcf-hcs@health.ny.gov Accounts Receivables and Recoupment: bimamail@health.ny.gov HCRA and Cash Assessment: hcraprov@health.ny.gov DSH or Indigent Care questions: dshaudits@health.ny.gov Establishment of locations on eMedNY: providerenrollment@health.ny.gov Billing questions: eMedNY Call Center: 1-800-343-9000